SIHO INSURANCE SERVICES

City of Crown Point Short Term Disability

City of Crown Point Employee will contact SIHO Insurance Services when it has been determined the employee will not be able to perform his/her work duties and requests Short Term Disability.

Short Term Disability point of contact at SIHO Insurance Services will be:

Linda Hessman
Short Term Disability Coordinator

Phone: 812-378-7010
Fax: 812-378-7114
Email: linda.hessman@siho.org

The Short Term Disability Coordinator will forward the Employee Statement and Physician Statement Forms via USPS mail, email or fax to the City of Crown Point employee. The Short Term Disability Coordinator will communicate to the City of Crown Point employee at that time, the STD benefits will not commence until the **completed** forms are returned to SIHO Insurance Services.

Once forms have been received, the Short Term Disability Coordinator will create an STD approval letter and forward to the Employee and City of Crown Point's HR Director. The letter will contain the date the approval dates for STD. The letter will also indicate the Employee will be required to submit updated physician information to continue the STD benefit.

The City of Crown Point HR Director information is:

Karen Marben
Human Resources Director

Phone: 219-661-2284
Fax: 219-662-1373
Email: kmarben@crownpoint.in.gov

417 Washington Street
Columbus, IN 47201
Phone: 812-378-7010 or 888-373-8528
Fax: 812-378-7114

SHORT TERM DISABILITY INCOME CLAIM FORM

INSTRUCTIONS TO EMPLOYEE

1. Statements should be completed as follows: Part A is to be completed by the Employee. Part B is to be completed by the employer. Part C is to be completed by the attending physician.
2. To avoid delay in processing, please be sure that all answers are complete.
3. The employer should mail the completed form to the above address.

PART A EMPLOYEE'S STATEMENT

Company Name _____ Occupation _____

Employee Name _____ Date of Birth _____

Social Security Number _____ Cell Phone ( ) Home Phone ( )

Home Address of Employee (Street, City, State, Zip) Please Print

Is this disability related to your employment? ☐ Yes ☐ No
Is this condition due to ☐ Accident ☐ Sickness.

Date accident occurred or illness began: *AM*
Date: _____ Hour _____ *PM*

Describe injuries received or nature of illness

If an accident, describe where and how the accident occurred:

Note: To avoid delay in evaluating your claim, advise your doctor to attach copies of medical records and test results.

How does your injury or sickness impede your ability to do your occupational duties?

Attending physican, (give Name, Address, Phone Number)

If confined in hospital, (give Name, Address, Phone Number)

Hospital Admission Date _____ Time: *AM* *PM* _____ Discharge Date: _____

Date totally disabled by this injury or illness and were totally unable to work Date _____

If presently working, give date that you returned to work Part Time ☐ Full Time ☐ Date _____

AUTHORIZATION

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any hospital or physician who has treated me or examined me, to furnish Southeastern Indiana Health Organization (SIHO), or their representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Signature of Employee _____ Date: _____

SHORT TERM DISABILITY INCOME CLAIM FORM

PART B — EMPLOYER'S STATEMENT	
Employee Name	
Employee Department	Hire Date:
Employee last worked	Disability Payments begin:
Date paid through:	
Has Employee returned to work? ☐ Yes ☐ No	Date Returned
Date: Employer	
Mailing Address (Street, City, State, Zip Code)	
By (Authorized Employer Representative) **Please Print**	
Name	Title
Signature of Employer Representative	

SHORT TERM DISABILITY INCOME CLAIM FORM

PART C	ATTENDING PHYSICIAN'S STATEMENT (Please Print)
Name of Patient:	Date of Birth: Social Security #:
Date of last examination:	
Diagnosis (including complications) and other conditions; Include ICD9 Code	
Objective findings (including current x-rays, labs, or psychiatric testing). Attach test results.	

DETAILS OF DISABILITY	
Is this condition due to: ☐ Accident ☐ Pregnancy ☐Illness	If pregnancy, expected delivery date:
If delivered, actual delivery date:	Delivery type: ☐ Normal ☐ C-Section
Symptoms first appeared or accident occurred	Date:
Is the accident or sickness related to employment?	☐ Yes ☐ No
Date of first visit for illness or injury:	Date last visit:
Date of next visit	Frequency of visits:
Patient is: ☐ Ambulatory ☐ Hospital confined ☐ House confined	

INFORMATION ABOUT PATIENT'S ABILITY TO WORK		
If patient has loss of function, please provide restrictions and limitations including dates.		
Restrictions:		
Limitations:		
Is patient still under your care? ☐ Yes ☐ No		Expected return to work date:
Patient was continuously totally disabled (unable to work)	From:	to:
Patient partially disabled	From:	to:
Referring physician or other treating physician. (give name, address and phone number)		

REQUIRED ATTACHMENTS AND SIGNATURES		
Please make sure that office notes, last results, and discharge summaries are attached. This will help reduce additional requests.		
FRAUD NOTES: Any physician who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. The above statements are true and complete to the best of my knowledge and belief.		
Print or Type Name:	Degree:	Medical Speciality:
Street Address:		Phone #:
City: State: Zip Code:		Fax #:
Signature of Physician		Date